

<i>SERFF Tracking Number:</i>	<i>GHPI-125882206</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Coventry Health and Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40732</i>
<i>Company Tracking Number:</i>	<i>ARABO08</i>		
<i>TOI:</i>	<i>H15G Group Health - Hospital/Surgical/Medical Sub-TOI:</i>		<i>H15G.001 Any Size Group</i>
	<i>Expense</i>		
<i>Product Name:</i>	<i>Applicaton for Benefits Offerings</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: Applicaton for Benefits Offerings
 SERFF Tr Num: GHPI-125882206 State: ArkansasLH

TOI: H15G Group Health - Hospital/Surgical/Medical Expense
 SERFF Status: Closed State Tr Num: 40732

Sub-TOI: H15G.001 Any Size Group
 Co Tr Num: ARABO08 State Status: Approved-Closed
 Filing Type: Form Co Status: Reviewer(s): Rosalind Minor

Authors: Geneva Clark, Anita Carter
 Disposition Date: 12/16/2008

Date Submitted: 10/31/2008
 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
 Implementation Date:

State Filing Description:

General Information

Project Name:
 Project Number:
 Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
 Submission Type: New Submission

Overall Rate Impact:
 Filing Status Changed: 12/16/2008

State Status Changed: 12/16/2008

Corresponding Filing Tracking Number:

Filing Description:

Filing for a group Application for Benefits Offerings

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Deemer Date:

SERFF Tracking Number: GHPI-125882206 State: Arkansas
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 40732
Company Tracking Number: ARABO08
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
Expense
Product Name: Applicaton for Benefits Offerings
Project Name/Number: /

Company and Contact

Filing Contact Information

Anita Carter, Manager of Regulatory Compliance
acarter@cvty.com
550 Maryville Centre Drive (314) 506-1928 [Phone]
St. Louis, MO 63141-5818 (314) 506-1672[FAX]

Filing Company Information

Coventry Health and Life Insurance Company CoCode: 81973 State of Domicile: Delaware
6705 Rockledge Drive Group Code: 1137 Company Type:
Suite 900
Bethesda, MD 20817 Group Name: State ID Number:
(314) 506-1700 ext. [Phone] FEIN Number: 75-1296086

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

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TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
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Product Name: Applicaton for Benefits Offerings

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/16/2008	12/16/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/31/2008	10/31/2008	Anita Carter	12/15/2008	12/15/2008

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	Expense		
Product Name:	Applicaton for Benefits Offerings		
Project Name/Number:	/		

Disposition

Disposition Date: 12/16/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: GHPI-125882206 *State:* Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Application for Benefits Offerings	Approved-Closed	Yes

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Product Name: Applicaton for Benefits Offerings
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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/31/2008
Submitted Date 10/31/2008
Respond By Date
Dear Anita Carter,
This will acknowledge receipt of the captioned filing.

Objection 1

- Application for Benefits Offerings (Form)

Comment: The application must contain a Fraud Statement as outlined under ACA 23-66-503 and Bulletin 7-97.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 12/15/2008
Submitted Date 12/15/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: 12/15/08

Ms Minor:

The paragraph proceeding the questions in "Section IV Claims History" includes the following statement: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage."

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Per ACA 23-66-503 (a) documents "...shall contain the following statement or a substantially similiar statement.."
Would the statement as provided in Section IV not qualify as meeting this regulation as being "a substantially similiar statement"?

Sincerely,
Anita J. Carter
314-506-1928

Related Objection 1

Applies To:
- Application for Benefits Offerings (Form)
Comment:
The application must contain a Fraud Statement as outlined under ACA 23-66-503 and Bulletin 7-97.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Anita Carter, Geneva Clark

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Product Name: Applicaton for Benefits Offerings

Project Name/Number: /

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-	CHTN	Application/	Application for	Initial			CHTN 00043
Closed	00043 (10-08)	Enrollment Form	Benefits Offerings				(10-08).pdf

APPLICATION FOR BENEFITS OFFERINGS

Incomplete information will delay processing application

Application is hereby made to Coventry Health and Life Insurance Company (CHL) by the Applicant named herein for the purpose of making CHL available to provide access to certain health and other benefits as specified below. CHL’s issuance of the Group Enrollment Agreement (GEA) shall be based upon the information contained in this application. The GEA, Certificate of Coverage (COC) and Amendments, Enrollment/Change Form, Applicable Riders, Member Handbook, Provider Directory, and Schedule of Benefits will become the definitive agreement relating to the provision of health benefits during the term and any renewal terms of the GEA.

I. GROUP INFORMATION

Group No.:	Effective Date:	SIC Code:	No. of Total Employees:	No. of Eligible Employees:	No. of Employees Applying for Coverage:
Type of Organization:				Federal Tax ID #:	
Company Name:					
Company Address: Street		City	State	Zip	
Telephone Number: ()		Fax Number: ()		E-Mail Address:	
Billing Address: Street		City	State	Zip	
Prior/Current Health Insurer Carrier (for deductible credit):					
Dates of Coverage:		Annual Deductible:		Administered Per: <input type="checkbox"/> Contract Year <input type="checkbox"/> Calendar Year	
Administrative/Billing Contact:			Decision Maker:		
Covered Subsidiaries:					

Employer Contribution	Employee	Employee & Spouse /Employee & One	Employee & Child(ren)	Family

Sold Rates	Employee	Employee & Spouse/ Employee & One	Employee & Child(ren)	Family

II. ELIGIBILITY INFORMATION

Eligible Employee:

☐ All Full-Time employees working _____ hours

☐ Other _____

Employee Termination Date of Coverage:

☐ Date employment ends

☐ Last day of the month

Dependent Children Coverage Terminates:

☐ Actual birthdate

☐ Last day of the month

☐ End of calendar year

Employee Effective:

☐ The date of hire

☐ The first of the month following the date of hire

☐ The first of the month following **30 days** of becoming an eligible employee

☐ The first of the month following **60 days** of becoming an eligible employee

☐ The first of the month following **90 days** of becoming an eligible employee

☐ The first of the month following **120 days** of becoming an eligible employee

☐ The first of the month following **180 days** of becoming an eligible employee

☐ Other _____

Community Mental Health Center—Employer elects to provide coverage for benefits arising from mental illness for treatment received at the community mental health center. [TN Code 56-7-2601(b)] (TN Only) ☐ Yes ☐ No

Mental Health Rider—Employer elects to provide coverage for benefits arising from mental illness (for groups of 100 or less eligible employees only). [MS Code 83-9-41] (MS Only) ☐ Yes ☐ No

TMJ Treatment—Employer elects to provide coverage for Medically Necessary treatment related to musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD). [AR Code 23-79-150] (AR Only) ☐ Yes ☐ No

Dependent children are eligible for coverage until: (AR Only)

☐ Up to the 19th birthday or 23rd birthday if full time student

☐ Up to the 19th birthday or 24th birthday if full time student (May impact rates)

☐ Up to the 19th birthday or 25th birthday if full time student (May impact rates)

☐ Up to the 23rd birthday or 25th birthday if full time student (May impact rates)

☐ Up to the 23rd birthday (May impact rates) (Coventry may audit your determination at any time)

☐ Other _____

Student Eligibility Determination: (AR Only)

☐ We wish for CHL to monitor

☐ We wish to determine our own (Coventry may audit your determination at any time)

Extended Layoff Coverage:

☐ Offer an extension of coverage during layoff

☐ Not to offer an extension of coverage during layoff

III. BENEFITS SELECTION

Benefits Selected:

☐ Medical (Select adjacent product & plan) _____

☐ Prescription Drug Rider # _____

☐ Dental Rider # _____

☐ Life: _____

☐ Other: _____

IV. CLAIMS HISTORY (Attach additional sheets if necessary).

The Group certifies that this information is complete and true and to the best knowledge of person signing below and that false statements may be grounds for re-rating or cancellation of coverage. It is a crime to knowingly provide false, incomplete or misleading information to an insurance for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. It is understood that Coventry Health and Life Insurance Company intends to rely on this information for the purpose of rating and premium determination and not for the purpose of engaging in activities or inquiries prohibited by federal or state law(s).

Are there any employees who are not actively performing their duties full-time due to a disabling injury or illness? ☐ Yes ☐ No If Yes, Please explain:

Are there any employees or dependents who are currently incapacitated, confined in a hospital or treatment facility, being treated for a serious illness or had \$5,000 or more in medical expenses in the past twelve (12) months? ☐ Yes ☐ No If Yes, Please explain:

Are there any employees or dependents on COBRA continuation? ☐ Yes ☐ No If Yes, Please explain:

V. BROKER INFORMATION

Broker/Consultant Name:	Agency:
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Broker/Consultant Signature

Date

DO NOT CANCEL EXISTING GROUP INSURANCE UNTIL YOU HAVE BEEN NOTIFIED OF YOUR GROUP’S ACCEPTANCE BY CHL.
No rates shall go into effect until final rates have been determined and accepted.

Company Name

Signature of Applicant

Date

Title (Officer of Company)

CHL Representative Signature

Date

CHL Representative Title



VI. DENTAL COVERAGE

Employer Contribution	Employee	Employee & Spouse/ Employee & One	Employee & Child(ren)	Family

Sold Rates	Employee	Employee & Spouse/ Employee & One	Employee & Child(ren)	Family

Dental Plan Name: _____ Dental Plan Code: _____ Prior dental coverage? ☐ Yes ☐ No

For all eligible employees, the employer agrees to contribute an amount equal to at least 50% of the employee premium. For contribution amounts less than 50%, the rates will be increased to voluntary levels.

Signature of Applicant	Date
------------------------	------

CHL Representative Signature	Date
------------------------------	------



VII. LIFE COVERAGE

For groups with 50 or fewer eligible employees

Employee Life and Accidental Death and Dismemberment

Life insurance products are underwritten by Coventry Health and Life Insurance Company. *Fraud Warning. Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer or submits an application containing a false or deceptive statement may have violated state law. Minimum of \$10,000 is required.*

Step One: Check one uniform employee flat-dollar coverage amount from the options available to your group size. All options include employee Accidental Death and Dismemberment coverage, as defined by the Policy.

Available to groups with 50 or fewer eligible employees:
☐ \$10,000 ☐ \$15,000 ☐ \$20,000 ☐ \$25,000

Additional options available to groups with 10 to 50 eligible employees:
☐ \$30,000

Employer Contribution _____

Step Two: Coventry Health & Life also offers dependent coverage as an option. The coverage is \$5,000 spouse, \$2,000 per eligible child. (Check “Yes” if you choose to offer dependent life coverage.)

☐ Yes ☐ No

For groups with 51 or more eligible employees

Employee Life and Accidental Death and Dismemberment

Life insurance products are underwritten by Coventry Health and Life Insurance Company. *Fraud Warning. Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer or submits an application containing a false or deceptive statement may have violated state law.*

Step One: Define Employee Classifications:

Amounts of basic group life insurance should be a uniform percentage of salary or flat amount for each employee. You can select group life insurance based upon employee classifications. If you would like to separate your employee population into classes, please do so here and indicate the benefits each class is to receive by inserting the class number as requested next to the benefit selections in Steps Two through Six below. **Note:** The classifications must not exceed 2.5 times between each class or 10 times between the lowest and highest class.

Class #	Definition
1:	_____
2:	_____ (No more than 3 classes may be used.)
3:	_____

Step Two: By employee class, choose the method determining the basic group term life insurance amount, either Salary Multiple (1x, 1.5x or 2x) or Flat Dollar Amount

Class _____	<input type="checkbox"/> Flat \$ _____	<input type="checkbox"/> Multiplier _____	Employer Contribution _____
Class _____	<input type="checkbox"/> Flat \$ _____	<input type="checkbox"/> Multiplier _____	Employer Contribution _____
Class _____	<input type="checkbox"/> Flat \$ _____	<input type="checkbox"/> Multiplier _____	Employer Contribution _____

Step Three: Accidental Death & Dismemberment: Employee (Choose “Yes” if electing to offer Employee Accidental Death & Dismemberment coverage)
☐ Yes If yes, class #s _____ ☐ No

Step Four: Dependent Life (Choose “Yes” if electing to offer dependent life coverage)
☐ Yes If yes, class #s _____ ☐ No

If you choose to offer Dependent Life, which option would you like to offer?

- ☐ Fixed coverage: \$5,000 Spouse/\$2,000 Child: Class #s _____
- ☐ Fixed coverage: \$10,000 Spouse/\$5,000 Child: Class #s _____
- ☐ Variable Spouse with Fixed Child: Class #s _____
 - Spouse coverage amount selected by employee in \$10,000 increments up to 50% of employee coverage
 - \$2,000 Child
- ☐ Variable Spouse with Fixed Child: Class #s _____
 - Spouse coverage amount selected by employee in \$10,000 increments up to 50% of employee coverage
 - \$5,000 Child

Step Five: Accidental Death & Dismemberment: Dependent (Choose “Yes” if electing to offer Dependent Accidental Death & Dismemberment coverage)
☐ Yes If yes, class #s _____ ☐ No

Step Six: Employee Supplemental Life (Choose “Yes” if electing to offer Employee Supplemental Life coverage)
☐ Yes If yes, class #s _____ ☐ No

Step Seven: Custom coverage is only available for groups with more than 250 eligible employees. If you are electing custom coverages, please indicate them below

If you choose to offer Employee Supplemental Life coverage, your choice for multiple of salary vs. fixed dollar basic employee life coverage in Step One above will also apply in this category. For example, if you elected fixed coverage, employees will be able to choose supplemental life coverage in \$10,000 increments up to plan maximum. If you elected multiple of salary, employees will be able to choose supplemental life coverage as 1x, 1.5x or 2x salary, up to plan maximum.

Guaranteed Issue Amounts: Amounts in excess of the guaranteed issue are subject to evidence of insurability. Guaranteed issue amount for groups with 51 eligible employees or greater is \$150,000.

Note: The face amount of all coverages under the Policy are subject to the following age reduction schedule:

Age:	Coverage Reduction
65 to 70	65%
70 to 75	40%
75 to 80	25%
80 and over	20%

Signature of Applicant _____

Date _____

CHL Representative Signature _____

Date _____

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TOI:	H15G Group Health - Hospital/Surgical/Medical Sub-TOI:		H15G.001 Any Size Group
	Expense		
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Project Name/Number:	/		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: GHPI-125882206 State: Arkansas
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TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
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Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 12/16/2008
Comments:
A cover letter and the readability certificate for this filing is attached.
Attachments:
CHTN 00043 (10-08) Initial Cover Ltr.pdf
Readability Certification.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 12/16/2008
Comments:
The attached is an application to be completed by the group.



(314) 506-1928
acarter@cvty.com

October 31, 2008

Rosalind Minor
Sr. Certified Rate & Form Analyst
Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, Arkansas 72201

Re: Co Tracking #: ARABO08
Application for Benefits Offerings

Dear Ms Minor:

I am writing on behalf of Coventry Health and Life Insurance Co. ("CHL") regarding submission of the above referenced documents outlined in the attached list.

The intended market for these documents is the employer group market. This document is a new, rather than replacement document. This document will be issued to employers.

In addition, please note the following:

1. A check in the amount of \$20.00 will be sent under separate cover as per our email discussion on September 25, 2008.
2. In compliance with ACA 23-79-206, a Readability Certificate is attached.
3. In compliance with Rule & Regulation 19, these documents do not discriminate on the basis of sex.
4. Rule & Regulation 49 does not apply to this filing.
5. ACA 23-79-138 does not apply to this filing. The address and phone number of the AR Insurance Department is listed in the member's Certificate of Coverage.

Thank you for your assistance with this filing. If you have any comments or concerns, please contact me at (314) 506-1928.

Sincerely,

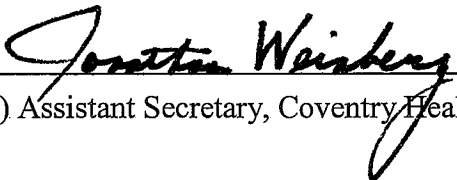
A handwritten signature in black ink, appearing to read "Anita J. Carter". The signature is fluid and cursive, with the first name "Anita" being more prominent and the last name "Carter" following in a similar style.

Anita J. Carter, RN
Manager, Regulatory Compliance

READABILITY CERTIFICATION

I hereby certify that the following forms comply with the Arkansas minimum Flesch reading ease test scores pursuant to A.C.A. § 23-80-206:

CHTN 00043 (10-08)


(Signature) Assistant Secretary, Coventry Health & Life Insurance Company

Jonathan D. Weinberg
(Print Name)

October 31, 2008
(Date)